Hey everyone,

We wanted to just share some comment with regard the MHSOAC's efforts around suicide prevention.

I will only speak for Fresno. We in Fresno are one of a handful of Counties that have a formal suicide prevention plan, which provides direction and clear strategies (including zero suicide) as well as being developed and implemented across sectors (so education, health care, first responders, and behavioral health service providers).

That is important when we are talking about what are service and program needs, having plans help better identify needs and drive responses and services. A cross sector plan allows a county to work with all its partners to address, prevent, respond to matters related to suicide, than do to it individually. Often the voices who provide input for things like suicide prevention are from just the behavioral health sector vs cross sector, and/or are siloed responses vs through cross section partnerships, often resulting in addressing only part of the problem and not system wide.

Also for efforts to be effective it really needs to be localize, and thus allowing for local data and information. We have started to use data from deaths, having death reviews of suicides to better understand causes, understand trends, and inform our prevention efforts. Additionally, working with the CVSPH we are also able to gain info from calls to the life line, and who those are who are at risk. And there is where the Commission may best focus its attention. We are told of the at risk populations, but often those are based on national numbers, or statewide, but if and when you look at the data closely (either deaths, lifeline calls, and/or other data and the persons dying, attempting, etc.) on the local level do not align with the discussion on whom are at risk. Funding projects based on what are deemed at risk, without looking to see if those are the actual persons locally that need to be targeted can result in some prevention, but also miss the actual vulnerable populations which can result in death.

So, there will be stakeholders who may suggest ideas and options, we just think its more effective if decisions can be made looking at need based on local data vs general and also understand where there are cross sectors collaboratives there may be more data informed and partnership to do the work, and when its individual sectors or stakeholder groups.

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Pronouns He | His | Him

For the FSP data, can you explain the origin of the data? Do counties input the data to you? If so, how? It would help those of us in the general community to know if this information is truly up to date (for our own county).

Thank you.

Sherry Bradley
Home: [redacted]
Cellular: [redacted]
email: [redacted]

Dear MHSOAC Commissioners and Staff - Thank you for your work regarding performance outcome data. As you work to identify, standardize and communicate this data, I encourage you to review: CALBHB/C's Performance Outcome Data Issue Brief which provides:

1. Related CA Law (including the roles of DHCS, MHSOAC, CBHDA, CBHPC and CA's 59 local Mental Health Boards & Commissions)
2. Suggested Data Points
3. Promising Data currently reported from specific counties by topic
4. Links to performance outcome data for all counties

Best Regards,

Theresa Comstock, Executive Director
CA Association of Local Behavioral Health Boards & Commissions
717 K Street, Suite 427 Sacramento CA 95814
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www.calbhbc.org Newsletter Resources

CALBHB/C supports the work of CA's 59 local Mental/Behavioral Health Boards and Commissions

I had my hand raised and wasn't called during public comment period. NOTE: It was difficult hearing coordinator doing public comment period. With hand raised, it block part of closed captioning as I am hard of hearing myself.

I support the project as it deals with both cultural identity and mental health.

My only concern is there is no peer support with this project.

Peer Support makes a difference in the lives of individual with lived experiences.

I was a peer counselor in High School during my senior year. Peer counseling helped me identify myself as a consumer with mental health and set my goals in working instead of going on disability benefits after graduating from high school. Here 32 learn later I'm still working as a Mental Health Worker at a local Psychiatric Health Facility (PHF) in 5150 unit.

There is a stigma within Filipino family and a taboo with mental health as it was in my cultural being Latino.

Peer Support Workers needs to be part of this project in making positive strides with children, youth, and their families.

Please include my comments.

Respectfully,

Mental Wellness is possible

With regards,

Richard Gallo
State Ambassador/Bay Area Region Ambassador
ACCESS California CAL VOICES
(707) 572-HELP (ACCESS Ombudsman and Advocacy)
www.accesscalifornia.org

My name is Lowellyn Sunga and I work from the San Mateo County Pride Center. I am a Filipino American and identity as a lesbian. I grew up in the Bay Area and lived in San Francisco and Daly City, so I know first hand the impact and importance of having a Filipinx Community Center.

- Some background about me growing up in San Mateo County, my parents are immigrants from a providence in the Philippines, where they were raised came from a very strict catholic background. For me, being gay was a discussion I never felt comfortable talking about my sexuality since it was so taboo and still is taboo. I did not come out until college. I feel like if I had a safe place that was easily accessible when I was younger, I would have came out sooner. This is why it is so important for the younger generation to have, a Center like this.

- I think once we get the Filpinx Social Enterprise Community Center established and ready for the doors to be open, there will be so many people in this county will be using all of the services that they provide for this County, especially North County.

- To be able for the youth go be themselves, no matter what, who they are and who they love, without judgement. That is home.

Good Morning!

I am currently attending the MHSOAC Zoom meeting. I had hoped to make an open public comment of introduction, but for some unknown reason I am lacking the option button to raise my hand, and chat is disabled; thus, I am following up in email to introduce myself and the plight of my industry.

Thank you for allowing public attendance of the meeting. I am a Veterinarian and solo practice owner in Vallejo, CA, as well as an Emotional CPR Trainer through the National Empowerment Center, and a member of the Veterinary-Human Support Certificate Program through the College of Social Work at the University of Tennessee. My practice currently covers Solano, Napa, Sonoma, Marin, Yolo, Contra Costa, and Southern California counties, and I have a heavy focus on veterinary and animal healthcare worker mental health and wellness.

There is zero representation for the veterinary community in the mental health commission, and I intend to change that. As an individual with lived experience, as well as nearly 20 years' as a practicing veterinarian, I have both experienced and witnessed the significant mental health issues affecting our industry. In exhaustive research on grants I come up empty-handed with funding directed towards the veterinary industry outside of Covid-impact business support. This support is directed more towards business finances than mental health, and it is widely unknown in both professional and public circles that Veterinarians suffer a pinnacle suicide rate (men 2.1%, women 3.5%) higher than the general public, serious mental health issues, worsening industry statistics for job satisfaction and career recommendation, and so much more. I am losing veterinarian friends and colleagues at an alarming rate to suicide and there is a serious lack of mental health support and education for my industry.

In current articles the focus is on financial stress from student loans and client restrictions, ethical issues surrounding euthanasias, compassion fatigue and burnout, peer and client bullying, long hours and excessive expectations, litigation, and high staff turnover. What is not discussed is the serious lack of education on healthy boundaries, embodied and empathetic listening and communication skills, recognizing signs of mental illness in self and colleagues, living by core values, radical acceptance, deep self-care, and financial management for improved mental health. Providing a suicide hotline number in a clinic is a simple step frequently recommended, yet wholly misses the profound need for often high-functioning, perfectionistic, type-A carers embarrassed or reluctant to reach out for help, to be deeply heard and understood via peer and professional support, a return to embodied empathy, and self-recognition of the signs and symptoms of mental health issues and how to reverse the suicide rate through compassionate understanding rather than a purely referral approach.

I appreciate your time and attention, and hope that this will open the door to further discussion on how I can be directly involved in bringing change, open grant funding specific to my industry's serious mental health needs, and be a voice for my veterinary and animal healthcare colleagues who are desperate need of mental health support and services. I sincerely hope there would be an opportunity to present this information to the commission.

With gratitude,
Joanna Robson, DVM
[redacted]